

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034991

Facility Name: PARK HOUSE

Address: 2320 SOUTH LAWNDALE CHICAGO 60623
Number City Zip Code

County: COOK

Telephone Number: (847) 329-1555 Fax # (847) 329-9555

IDPA ID Number: 36-3620976

Date of Initial License for Current Owners: 01/01/89

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	SHERWIN I. RAY	
	(Title)	PRESIDENT	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
		(Date)	
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585 Fax # (847) 675-5777	
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number PARK HOUSE

0034991 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>14</u>	Skilled (SNF)	<u>14</u>	<u>5,110</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>92</u>	Intermediate (ICF)	<u>92</u>	<u>33,580</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,690</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,305</u>	<u>2,305</u>	8
9	SNF/PED					9
10	ICF	<u>30,292</u>			<u>30,292</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,292</u>		<u>2,305</u>	<u>32,597</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.25%

D. How many bed-hold days during this year were paid by the Department? 312 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 01/01/89

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 01/01/89 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 2,305

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **PARK HOUSE**# **0034991**

Report Period Beginning:

01/01/2005

Ending:

12/31/2005**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	157,226	17,218	6,553	180,997		180,997		180,997			1
2	Food Purchase		131,752		131,752	(18,889)	112,863	(246)	112,617			2
3	Housekeeping	116,114	17,260		133,374		133,374		133,374			3
4	Laundry	33,815	10,581		44,396		44,396		44,396			4
5	Heat and Other Utilities			90,825	90,825		90,825	34	90,859			5
6	Maintenance	22,472	15,529	36,461	74,462		74,462	4,364	78,826			6
7	Other (specify):*			10,585	10,585		10,585	26	10,611			7
8	TOTAL General Services	329,627	192,340	144,424	666,391	(18,889)	647,502	4,178	651,680			8
	B. Health Care and Programs											
9	Medical Director			8,200	8,200		8,200		8,200			9
10	Nursing and Medical Records	822,454	29,978	51,545	903,977		903,977	(29,503)	874,474			10
10a	Therapy	16,792	571	82,811	100,174		100,174	(560)	99,614			10a
11	Activities	62,682	11,594	3,108	77,384		77,384		77,384			11
12	Social Services	136,800		744	137,544		137,544		137,544			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,038,728	42,143	146,408	1,227,279		1,227,279	(30,063)	1,197,216			16
	C. General Administration											
17	Administrative	50,946		401,156	452,102		452,102	(155,349)	296,753			17
18	Directors Fees											18
19	Professional Services			227,344	227,344		227,344	(164,584)	62,760			19
20	Dues, Fees, Subscriptions & Promotions			24,353	24,353		24,353	278	24,631			20
21	Clerical & General Office Expenses	151,129	9,369	102,898	263,396		263,396	(134,871)	128,525			21
22	Employee Benefits & Payroll Taxes			278,826	278,826	18,889	297,715		297,715			22
23	Inservice Training & Education			809	809		809	887	1,696			23
24	Travel and Seminar							172	172			24
25	Other Admin. Staff Transportation			1,211	1,211		1,211	1,966	3,177			25
26	Insurance-Prop.Liab.Malpractice			49,238	49,238		49,238	998	50,236			26
27	Other (specify):*							38,605	38,605			27
28	TOTAL General Administration	202,075	9,369	1,085,835	1,297,279	18,889	1,316,168	(411,898)	904,270			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,570,430	243,852	1,376,667	3,190,949		3,190,949	(437,783)	2,753,166			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,770
	REPAIRS & MAINTENANCE		783
			0
			6,553
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		47,101
	ELECTRICITY		29,380
	WATER		13,129
	CABLE TV - LOBBY		1,215
			0
			90,825
6	MAINTENANCE		
	GROUNDS MAINTENANCE		3,223
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		19,369
	ELEVATOR MAINTENANCE & REPAIR		5,330
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		3,745
	FIRE SERVICE		4,794
			0
			0
			0
			36,461
7	OTHER		
	SCAVENGER		10,585
	SECURITY SERVICE		0
			10,585
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,200
			8,200

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	720
	PHARMACY CONSULTANT	XVIII B 39-2	825
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	50,000
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			51,545
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		1,836
	THERAPY CONTRACT SERVICE		69,581
	OCCUPATIONAL THERAPY SERVICES		594
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			82,811
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,108
			0
			3,108
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	744
			0
			744
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 401,156	401,156
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 22,834	
	ADMINISTRATIVE CONSULTANTS	XIX C 156,000	
	PROFESSIONAL FEES	XIX C 48,510	
		0	227,344
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 1,763	
	EMPLOYEE WANT ADS	XIX F 18,219	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 1,085	
	LICENSES & PERMITS	XIX F 2,779	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 7	24,353
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0	
	EQUIPMENT REPAIR & MAINTENANCE	6,529	
	OUTSIDE CLERICAL SERVICES	63,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18 20,535	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	380	
	TELEPHONE	11,854	
	MESSENGER SERVICE	0	
		0	102,898

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 119,433	
	UNEMPLOYMENT COMPENSATION	XIX D 43,889	
	WORKERS COMPENSATION INSURANCE	XIX D 50,385	
	HOSPITALIZATION INSURANCE	XIX D 42,508	
	EMPLOYEE BENEFITS - OTHER	XIX D 18,639	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 3,972	278,826
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	809	809
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	1,211	1,211
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	49,238	49,238
27	OTHER		
	BAD DEBTS	VI 24 0	
			0

GRAND TOTAL COLUMN 3 OTHER

1,376,667

PARK HOUSE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	131,752	PATIENT MEALS	97791
LESS SALES TAX	(246)	ADD EMPLOYEE MEALS	16425
	-----		-----
NET FOOD	131,506	TOTAL MEALS/YEAR	114216
TOTAL PATIENT CENSUS	32,597	NET FOOD	131506
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	114216

TOTAL PATIENT MEALS	97791	COST PER MEAL	1.15
		TIME EMPLOYEE MEALS	16425
ADD # EMPLOYEE MEALS/DAY	45		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	18889
	-----		=====
TOTAL EMPLOYEE MEALS	16425		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			24,630	24,630		24,630	32,667	57,297			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							286,538	286,538			32
33	Real Estate Taxes			82,179	82,179		82,179		82,179			33
34	Rent-Facility & Grounds			348,175	348,175		348,175	(313,265)	34,910			34
35	Rent-Equipment & Vehicles			33,458	33,458		33,458	(15,528)	17,930			35
36	Other (specify):*											36
37	TOTAL Ownership			488,442	488,442		488,442	(9,588)	478,854			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,186	110,526	163,712		163,712	(11,206)	152,506			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		53,186	168,561	221,747		221,747	(11,206)	210,541			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,570,430	297,038	2,033,670	3,901,138		3,901,138	(458,577)	3,442,561			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(20,138)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(246)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(20,535)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,763)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (43,182)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(415,395)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (415,395)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (458,577)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2005

[illegible]

Summary B

12/31/2005

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					SKOKIE	THERAPY
				2320 S LAWNSDALE	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 313,265	2320 S LAWNSDALE LLC		\$	\$ (313,265)	1
2	V	30	SL DEPRECIATION		" "		43,185	43,185	2
3	V	32	INTEREST		" "		250,874	250,874	3
4	V								4
5	V								5
6	V	10a	THERAPY SERVICES	82,811	CAREPLUS REHABILITATIVE SERVICES		80,290	(2,521)	6
7	V	39	ANCILLARY SERVICES	110,525	" "		99,319	(11,206)	7
8	V	35	EQUIPMENT RENT	20,123	" "			(20,123)	8
9	V	30	DEPRECIATION		" "		2,611	2,611	9
10	V	32	INTEREST		" "		2,728	2,728	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 526,724			\$ 479,007	\$ * (47,717)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	PSYCHIATRIC CONSULTANT	\$ 50,000	CAREPLUS MGMT INC	100.00%	\$	\$ (50,000)	15
16	V	17	MANAGEMENT FEE	219,600	" "			(219,600)	16
17	V	19	ADMIN CONSULTANT	156,000	" "			(156,000)	17
18	V	19	DATA PROCESSING	12,000	" "			(12,000)	18
19	V	21	CLERICAL FEES	63,600	" "			(63,600)	19
20	V	21	HOME OFFICE EXPENSE	104,556	" "			(104,556)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 605,756			\$ 0	\$ * (605,756)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	CAREPLUS MGMT INC	100.00%	\$ 34	\$ 34	15
16	V	6	MAINT & REPAIRS		" " "		1,624	1,624	16
17	V	6	MAINTENANCE SALARIES		" " "		2,740	2,740	17
18	V	7	SECURITY		" " "		26	26	18
19	V	10	NURSING SALARIES		" " "		20,497	20,497	19
20	V	10a	THERAPY SALARIES		" " "		1,961	1,961	20
21	V	17	ADMIN SALARIES		" " "		64,251	64,251	21
22	V	19	PROFESSIONAL FEES		" " "		3,416	3,416	22
23	V	20	ADVERTISING		" " "		2,541	2,541	23
24	V	21	OFFICE EXPENSE		" " "		20,087	20,087	24
25	V	21	OFFICE SALARIES		" " "		33,733	33,733	25
26	V	23	SEMINARS		" " "		887	887	26
27	V	24	TRAVEL		" " "		172	172	27
28	V	25	TRANSPORTATION		" " "		1,966	1,966	28
29	V	26	INSURANCE		" " "		998	998	29
30	V	27	EMPLOYEE BENEFITS		" " "		38,605	38,605	30
31	V	30	DEPRECIATION		" " "		7,009	7,009	31
32	V	32	INTEREST		" " "		32,936	32,936	32
33	V	35	EQUIPMENT RENT		" " "		4,595	4,595	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 238,078	\$ * 238,078	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	JAKOB BAKST				SEE ATTACHED			SALARY	11,773	17-7	2
3	SHERWIN I RAY				SCHEDULE			SALARY	11,773	17-7	3
4	ERIC ROTHNER							MGMT FEE	77,000	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 100,546		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **PARK HOUSE**# **0034991** Report Period Beginning: **01/01/2005** Ending: **2/31/2005**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CAREPLUS MANAGEMENT INC
Street Address 8320 SKOKIE BLVD.
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 329-1555
Fax Number (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	553,765	13	\$ 574	\$	32,597	\$ 34	1
2	6	MAINT & REPAIRS	PATIENT DAYS	553,765	13	27,588		32,597	1,624	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	553,765	13	46,540	46,540	32,597	2,740	3
4	7	SECURITY	PATIENT DAYS	553,765	13	444		32,597	26	4
5	10	NURSING SALARIES	PATIENT DAYS	553,765	13	348,203	348,203	32,597	20,497	5
6	10a	THERAPY SALARIES	PATIENT DAYS	553,765	13	33,317	33,317	32,597	1,961	6
7	17	ADMIN SALARIES	PATIENT DAYS	553,765	13	1,091,504	1,091,504	32,597	64,251	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	553,765	13	58,031		32,597	3,416	8
9	20	ADVERTISING	PATIENT DAYS	553,765	13	43,163		32,597	2,541	9
10	21	OFFICE EXPENSE	PATIENT DAYS	553,765	13	341,243		32,597	20,087	10
11	21	OFFICE SALARIES	PATIENT DAYS	553,765	13	573,059	573,059	32,597	33,733	11
12	23	SEMINARS	PATIENT DAYS	553,765	13	15,061		32,597	887	12
13	24	TRAVEL	PATIENT DAYS	553,765	13	2,923		32,597	172	13
14	25	TRANSPORTATION	PATIENT DAYS	553,765	13	33,401		32,597	1,966	14
15	26	INSURANCE	PATIENT DAYS	553,765	13	16,951		32,597	998	15
16	27	EMPLOYEE BENEFITS	PATIENT DAYS	553,765	13	655,825		32,597	38,605	16
17	30	DEPRECIATION	PATIENT DAYS	553,765	13	119,076		32,597	7,009	17
18	32	INTEREST	PATIENT DAYS	553,765	13	559,538		32,597	32,936	18
19	35	EQUIPMENT RENT	PATIENT DAYS	553,765	13	78,057		32,597	4,595	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,044,498	\$ 2,092,623		\$ 238,078	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	RELATED PARTY:2320 S.LAWNDALE LLC						\$					\$	1	
2	NOMURA		X	MORTGAGE								245,826	2	
3													3	
4	CAREPLUS MANAGEMENT	X		CAPITAL IMPR LOAN								5,048	4	
5													5	
	Working Capital													
6	CARE PLUS MGMT	X										30,641	6	
7	TAG 18	X										2,142	7	
8	CARE PLUS REHAB	X										2,881	8	
9	TOTAL Facility Related						\$		\$			\$	286,538	9
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$		14
15	TOTALS (line 9+line14)						\$		\$			\$	286,538	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.			\$	79,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	79,779	2
3. Under or (over) accrual (line 2 minus line 1).			\$	179	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	82,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	82,179	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	71,075	8	
		2001	72,924	9	
		2002	73,742	10	
		2003	78,046	11	
		2004	79,779	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

PARK HOUSE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0034991

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	16-26-105-075-0000	NURSING HOME	\$ 35,216.29	\$ 35,216.29
2.	16-26-105-080-0000	NURSING HOME	\$ 22,316.86	\$ 22,316.86
3.	16-26-105-079-0000	NURSING HOME	\$ 22,246.21	\$ 22,246.21
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 79,779.36	\$ 79,779.36

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **26,849**

B. General Construction Type: Exterior **BRICK** Frame Number of Stories

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,000	1995	\$ 100,000	1
2					2
3	TOTALS	51,000		\$ 100,000	3

Facility Name & ID Number **PARK HOUSE**# **0034991**

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1989		\$ 1,209,350	\$ 37,381	39	\$ 37,381	\$	\$ 649,988	4
5											5
6											6
7	RELATED PARTY - TAG 18					945		945			7
8	RELATED PARTY - TAG 18 IMPRV					557		557			8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1989		17,739	645	20	887	242	14,433	9
10	LEASEHOLD IMPROVEMENTS		1989		4,204		15			4,204	10
11	LEASEHOLD IMPROVEMENTS		1990		11,700	425	20	585	160	8,964	11
12	LEASEHOLD IMPROVEMENTS		1991		17,413	633	20	871	238	12,629	12
13	LEASEHOLD IMPROVEMENTS		1992		55,138	2,100	31.5	2,100		24,296	13
14	LEASEHOLD IMPROVEMENTS		1993		26,399	1,013	31.5	1,013		10,650	14
15	LEASEHOLD IMPROVEMENTS		1994		3,400	124	39	124		1,063	15
16	ROOF REPAIR		1995		1,500	55	39	55		418	16
17	ROOF-TOP HEAT/A/C		1996		10,000	364	39	364		2,637	17
18	CEILING TILE/DUMBWAITER REPAIR		1996		12,253	445	39	445		3,154	18
19											19
20	RE-ROOF		1996		80,861	2,073	39	2,073		19,346	20
21	FIXTURES/WINDOWS		1996		3,850	99	39	99		910	21
22	WINDOWS		1997		18,900	484	39	484		4,038	22
23	ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION		1997		3,228	83	39	83		703	23
24	DOOR & FLOORING		1997		2,922	75	39	75		641	24
25	ELEVATOR REPAIR		1997		3,125	80	39	80		670	25
26	WINDOWS		1998		12,600	323	39	323		2,504	26
27	TILE & FLOORING		1998		23,810	611	39	611		4,719	27
28	ELECTRICAL, PLUMBING AND ELEVATOR REPAIR		1998		31,238	801	39	801		6,116	28
29	NEW NURSE STATION		1998		24,271	622	39	622		4,899	29
30	WINDOW TREATMENTS AND BRAILLE SIGNS		1998		3,478	89	39	89		686	30
31	FIRE SYSTEM UPGRADE AND DAMPERS		1998		8,833	227	39	227		1,662	31
32	REAR PARKING LOT REPAIRS		1998		10,550	703	15	703		5,276	32
33	WINDOWS/CLOSETS/OUTLETS/DUMBWAITS/ROOF		1999		23,174	594	39	594		3,985	33
34	ROOF REPAIR		1999		18,365	471	39	471		3,081	34
35	FRONT RAMP REPAIR		2000		1,200	44	27.5	44		206	35
36	VINYL TILE/KITCHEN		2000		6,213	226	27.5	226		1,234	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DUMBWAITER REPAIR	2001	\$ 3,264	\$ 119	27.5	\$ 119	\$	\$ 570	37
38	SIDEWALK/TUCKPOINTING	2001	5,500	367	15	367		1,651	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	138	27.5	138		569	39
40	BOILER	2002	5,229	190	27.5	190		657	40
41	AC UNITS	2002	6,365	231	27.5	231		799	41
42	FLOORING	2002	2,328	85	27.5	85		294	42
43	FIRE PUMP REPAIR	2003	1,750	64	27.5	64		156	43
44	ELECTRICAL TO ROOFTOP UNIT	2003	1,951	71	27.5	71		175	44
45	PAINTING	2003	20,800	756	27.5	756		1,860	45
46	CEILING & DOOR REPAIR	2003	1,180	43	27.5	43		106	46
47	CONCRETE REPAIRS	2003	2,961	108	27.5	108		266	47
48	REBUILD NEW BATHROOMS	2004	7,478	272	27.5	272		397	48
49	WATER PUMP	2004	2,547	93	27.5	93		135	49
50	BOILER,BURNER,BACKSPLASH,GREASE TRAP/EXCAVATI	2005	8,945	153	27.5	153		153	50
51	WALL AC/CARPET	2005	14,131	237	27.5	237		237	51
52	ELEVATOR REPAIR/ ROOFTOP AC	2005	22,770	374	27.5	374		374	52
53									53
54									54
55									55
56									56
57	CARE PLUS REHAB								57
58	WINDOWS	2004	11,385	292	39	292		377	58
59	FLOORING	2004	30,110	772	39	772		1,512	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,798,208	\$ 56,657		\$ 57,297	\$ 640	\$ 803,400	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$ 11,370	\$	\$ (11,370)		\$	71
72	Current Year Purchases		2,354		(2,354)			72
73	Fully Depreciated Assets							73
74			7,054		(7,054)			74
75	TOTALS	\$	\$ 20,778	\$	\$ (20,778)		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,898,208	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,435	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,297	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,138)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 803,400	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$33,458
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$0	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 74,629	\$		\$ 74,629	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			203			203	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits			35,694			35,694	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				52,631		52,631	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY Other (specify):	39-2 & 39-3					555		555	13
14	TOTAL			\$		\$ 110,526	\$ 53,186		\$ 163,712	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (82170)	1,318,656		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,332		6
7	Other Prepaid Expenses	49,205		7
8	Accounts Receivable (owners or related parties)	1,387,792		8
9	Other(specify): <u>R.E TAX ESCROW</u>	43,676		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,811,661	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	387,616		15
16	Equipment, at Historical Cost	292,149		16
17	Accumulated Depreciation (book methods)	(338,985)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPLACEMENT RESERVE</u>	109,109		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 449,889	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,261,550	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 730,780	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,999		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,390		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 923,169	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,378		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,378	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 968,547	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,293,003	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,261,550	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,174,116	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(41,367)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,132,749	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	160,254	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 160,254	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,293,003	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,950,143	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,950,143	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	111,249	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 111,249	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,061,392	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	666,391	31
32	Health Care	1,227,279	32
33	General Administration	1,297,279	33
	B. Capital Expense		
34	Ownership	488,442	34
	C. Ancillary Expense		
35	Special Cost Centers	163,712	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,901,138	40
41	Income before Income Taxes (line 30 minus line 40)**	160,254	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 160,254	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,921	2,411	\$ 60,746	\$ 25.20	1
2	Assistant Director of Nursing	1,108	1,188	26,851	22.60	2
3	Registered Nurses	1,072	1,236	37,742	30.54	3
4	Licensed Practical Nurses	11,971	12,682	252,408	19.90	4
5	CNAs & Orderlies	42,207	46,291	425,286	9.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,099	1,296	16,792	12.96	8
9	Activity Director	1,760	1,857	24,733	13.32	9
10	Activity Assistants	4,351	4,612	37,949	8.23	10
11	Social Service Workers	7,609	8,436	136,800	16.22	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,161	33,115	15.32	13
14	Head Cook	5,495	6,372	47,243	7.41	14
15	Cook Helpers/Assistants	8,154	9,086	76,868	8.46	15
16	Dishwashers					16
17	Maintenance Workers	1,998	2,131	22,472	10.55	17
18	Housekeepers	12,003	13,277	116,114	8.75	18
19	Laundry	3,997	4,243	33,815	7.97	19
20	Administrator	1,184	1,223	50,946	41.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,759	9,815	151,129	15.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,956	2,139	19,421	9.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	118,628	130,456	\$ 1,570,430 *	\$ 12.04	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 5,770	1-3	35
36	Medical Director	O	8,200	9-3	36
37	Medical Records Consultant	N	720	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	825	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,108	11-3	44
45	Social Service Consultant	E	744	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	S	50,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 80,167		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? 500
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 475 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,035
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,889 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees